STATE OF CONNECTICUT
Department of Mental Health and Addiction Services
SUPPORTED RECOVERY HOUSING SERVICES

SUPPORTED RECOVERY HOUSING (SRH) DOCUMENTATION INSTRUCTIONS

To complete the case management requirement of SRH services, providers must maintain hard-copy service documentation files for each client whom you serve. DMHAS and ABH® will review these completed forms to verify the provision of case management services.

The goals of case management services are to: utilize a person-centered, strength-based approach and promote the active participation of the client in stating preferences and making decisions that support recovery skills, foster independent living, promote community integration and increase the length of overall health and recovery while decreasing the risk of relapse.

Case management assistance should support the client in securing basic needs, housing, employment, entitlements, transportation and treatment services. On-site services should include referrals to DSS entitlements, the GA Recovery Supports Program or Access to Recovery II program, vocational/educational opportunities, housing subsidies, medical or other treatment appointments, energy assistance, food stamps and other potential sources of income and community recovery supports.

Case Management supports are not meant to be provided in a group setting.

LIST OF SAMPLE FORMS

- Client Service Agreement
- Consent to Disclosure and Re-disclosure of Confidential Information and Records (ROI)
- Grievance Procedure
- Program Rules
- Intake Assessment Form
- Recovery Plan
- Job Readiness Form
- Progress Notes
- Discharge
- Sign In/Out Sheet
- Landlord Verification Form

• CLIENT SERVICE AGREEMENT

PURPOSE OF FORM: Helps set very clear expectations for the client of what s/he will get from the program.

WHAT IS ON THE FORM: In clear and simple terms, the provider should describe services offered at the supported recovery house.

WHEN THE FORM SHOULD BE COMPLETED: At intake - before the individual moves into the house. The client should sign indicating s/he has read and understands the rules of the house and program.

• RELEASE OF INFORMATION (ROI)

PURPOSE OF FORM: Protects the client's personal health information (PHI) and allows the client to specify under which circumstances and which parties have temporary permission to discuss his/her health information. Please note that it is illegal to discuss a client's services without an ROI - even with the best intentions.

WHAT IS ON THE FORM: The form explains a client's rights where his/her health information is concerned and explains that by completing the form s/he is giving the parties indicated permission to discuss PHI for the purposes of providing quality services. Please put the name of your house in line #2 and the name of any clinical/treatment provider in line #3.

WHEN THE FORM SHOULD BE COMPLETED: At intake. Additionally, if the form expires before services are complete, it should be completed again to extend through the end of services. Providers should recommend that clients make the form valid for 12 months.

• PROGRAM RULES

PURPOSE OF FORM: Outlines clearly the rules associated with SRH services.

WHAT IS ON THE FORM: A comprehensive list of house and program rules, including clearly defined consequences explaining what may happen should the client violate these rules.

WHEN THE FORM SHOULD BE COMPLETED: The form should be reviewed item by item at intake. The client should sign indicating s/he has read and understands the rules of the house and program.

• GRIEVANCE PROCEDURE AND GRIEVANCE LOG

PURPOSE OF FORM: Explains to a client that s/he has the right to complain without the risk of losing services solely for filing the complaint.

WHAT IS ON THE FORM: Explanation of how to file a grievance.

WHEN THE FORM SHOULD BE COMPLETED: At intake.

- **INTAKE ASSESSMENT FORM**

PURPOSE OF FORM: Obtains information about the client that helps better provide and coordinate services. This can include the client's history of use, needs, and strengths as well as basic demographic and contact information.

WHAT IS ON THE FORM: Sections for Demographic, SAGA status, Legal status, Entitlement and benefits, Family and other Supports.

WHEN THE FORM SHOULD BE COMPLETED: At intake or at the first case management meeting.

- **RECOVERY PLAN**

PURPOSE OF FORM: Documents the short-term goals the client will work toward while in the house/program.

WHAT IS ON THE FORM: Goals agreed upon by client and case manager, the expected date or timeframe over which both parties expect the goals to be met, and specific measurable action steps necessary to reach goals. This form is based on issues identified in the intake assessment.

WHEN THE FORM SHOULD BE COMPLETED: At the first case management meeting with client and reviewed at each subsequent meeting.

- **JOB READINESS**

PURPOSE OF FORM: Tracks employment searches and other work readiness steps taken by the client. This form is required of all clients when applying for their second month of SRH services. Case managers may find this form useful for tracking employment searches or other employment readiness activities for those clients who have a goal of finding employment.

WHAT IS ON THE FORM: Space for the client to indicate places s/he has gone seeking employment, dates of interviews, contact people at agencies, etc.

WHEN THE FORM SHOULD BE COMPLETED: Ongoing. The form will need to be submitted in order to receive the second 30 days of SRH services. The form should also be reviewed at case management meetings.

- **PROGRESS NOTES**

PURPOSE OF FORM: Records case management services. Notes should track the client's progress toward achieving goals, document the case manager's work on behalf of the client, and summarize the client's recovery status.

WHAT IS ON THE FORM: The client's name (and optionally, the client ID), the date of the session, a brief summary of the client's status and steps taken towards his or her recovery goals, and the case manager's signature.

WHEN THE FORM SHOULD BE COMPLETED: At least weekly, and after every meeting with the client.

- **DISCHARGE SUMMARY**

PURPOSE OF FORM: A brief Discharge Summary should be completed when each client completes services successfully or leaves services prematurely. This form summarizes the client's progress on goals, next steps (including any referrals), and recovery status at the time of discharge.

WHAT IS ON THE FORM: Reason for discharge, employment status and living situation at the time of discharge, any service referrals.

WHEN THE FORM SHOULD BE COMPLETED: Directly before or directly after discharge, depending upon the circumstances.

- **SIGN IN/OUT**

PURPOSE OF FORM: Record when a client leaves and returns to the house.

WHAT IS ON THE FORM: Space for a client to sign in and out of the house.

WHEN THE FORM SHOULD BE COMPLETED: Each time a client leaves and returns to the house.

- **PROVIDER VERIFICATION FORM**

PURPOSE OF FORM: Required part of the request for housing under GA RSP.

WHAT IS ON THE FORM: Client information related to the housing request.

WHEN THE FORM SHOULD BE COMPLETED: Initial GA RSP application.

STATE OF CONNECTICUT
Department of Mental Health and Addiction Services
SUPPORTED RECOVERY HOUSING SERVICES

CLIENT SERVICE AGREEMENT

I understand that an approval for Supported Recovery Housing (SRH) services will mean:

- I will have a clean, safe, drug and alcohol-free living environment.

- There will be staff/workers who:
  - are available 8 hours a day to assist with recovery planning and available on call 24 hours a day for urgent situations;
  - understand the principles of recovery and are respectful of my recovery;
  - are competent and are able to address or help me address my unique needs;
  - will be positive role models; and
  - will not discriminate against me based on my age, race, color, ethnicity, gender, national origin, sexual orientation, religion, mental/physical disability or political affiliation.

- My case manager will help me accomplish the following, based on my needs:
  - obtain basic needs such as food, personal care, clothing and transportation;
  - connect me to treatment;
  - connect me to local self-help and support groups like NA/AA or church meetings;
  - obtain employment;
  - complete benefit or entitlement applications; and
  - talk about relapse prevention and stressful situations.

- I understand I will need to:
  - work with the case manager to make a short-term recovery plan and do my best to meet the goals I set for myself;
  - not break the rules and regulations of the house;
  - not endanger the recovery of the people who share the house with me;
  - try to resolve any issues I have through my case manager; and
  - submit to alcohol or drug screenings as requested.

- With an approval through the General Assistance Recovery Support Services (GA RSP) or Access to Recovery (ATR) II program, $500 per month will be paid on my behalf to the housing provider, and I will not be charged any additional fees for housing or case management services.

- The maximum time period I may receive GA RSP or ATR II payment for SRH services is 60 days. The time period may be reduced based on my previous use of the GA RSP or ATR II programs.

I, _____(*Your Name*), have read and understand everything written above and agree to fully participate in supported recovery housing services.

_____ _____
Client Signature Date

STATE OF CONNECTICUT
Department of Mental Health and Addiction Services
SUPPORTED RECOVERY HOUSING SERVICES

CONSENT TO DISCLOSURE AND RE-DISCLOSURE OF CONFIDENTIAL INFORMATION AND RECORDS

Release of Information

I, _____, DOB: _____,
(Name of Participant) (Date of Birth)

EMS#: _____, SS#: _____ as a
(EMS Number) (Social Security Number)

participant in the DMHAS General Assistance Recovery Support Services (GA RSP) or the Access To Recovery (ATR) II Program, understand my support services will be coordinated through DMHAS and the DMHAS designated Administrative Service Organization (ASO). I authorize the following individuals and organizations to release and exchange information to each other for the purpose of processing GA RSP and ATR II requests:

1. The DMHAS Administrative Service Organization; and

2. _____

3. _____

This information may include: my name, address, age, gender, Social Security Number, clinical assessment, progress in care, the type and outcome of mental health and addiction services I have received/am currently receiving, GA RSP or ATR II support history and such other information as is necessary to provide effective coordination of the treatment and services I receive.

The purpose of the disclosure authorized herein is to facilitate the provision of GA RSP or ATR II recovery supports.

I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2 and Chapter 899 of the Connecticut General Statues, and cannot be disclosed without my written consent unless otherwise provided for in the regulations or statutes. I have received a summary of the federal law protecting this information and a statement of the intended use of this information. I understand that the federal regulations restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient, and I understand that the rules prohibiting re-disclosure to third parties without my written consent will be strictly adhered to. I also understand that I may revoke this at any time except to the extent that action has been taken in reliance on it. Unless revoked by me, this consent shall expire upon completion of this application, or:

_____
[Specific date, event or condition upon which this consent expires, only if different from above]

Date: _____ _____
(Signature of Participant)

PROGRAM RULES

Please sign the document to indicate your full understanding and agreement to follow these house rules. Please note that each housing provider may have additional rules that are required.

1. Alcohol and Drugs
    a. Absolutely no alcohol or drug use by any client, staff or visitor of the house on or off the premises. Law enforcement officials will be notified if there is illegal drug use in the house by any client or visitor. Any client possessing or using alcohol or drugs will be immediately discharged.
    b. The program staff have the right to request clients to provide a urine sample or other drug test, including random testing. If a client fails to submit to any testing, the client will be immediately discharged.
2. Guests and Visitors
    a. There are no visitors allowed in the house without the consent of the program staff, and guests are only allowed in common areas. Guests are not permitted to stay overnight.
3. Smoking
    a. Smoking will only be allowed in designated areas.
4. Health and Medications
    a. Please inform staff of any and all medical conditions.
    b. All clients are responsible for the safety and administration of any medications they may have. All medications must be documented with program staff at intake.
5. Clients should begin actively seeking a sponsor immediately, and should obtain one within 30 days of admittance.
6. Complaints
    a. All clients are encouraged to use the written grievance procedure should they have a disagreement. There is a grievance procedure posted at each program.
7. Behavior and Personal Relationships
    a. Sexual relationships between any clients in the house (including the staff) are not acceptable.
    b. Clients are not allowed to borrow money from other clients or staff.
    c. Stealing of anything will result in immediate discharge.
    d. No threatening, violence, or acts of dishonesty.
8. Curfew and Check-in
    a. Clients must sign out when leaving the premises and sign in upon return.
    b. Clients must adhere to the curfew set by the housing provider.
9. Limit the use of internet and phone services (if available) to 15-minutes.
10. Any outstanding warrants must be documented at intake, and addressed within 30 days of admittance.
11. In the case of an emergency, call 911 immediately and then notify staff.
12. Mandatory Meetings:
    a. The minimum mandatory meetings will be.
        i. 1 weekly housing meeting
        ii. 5 self-help meetings per week during the first 30 days
        iii. 3 self-help meetings per week during the second 30 days
        iv. weekly meeting with the case manager
    b. Other mandatory meetings may be set by the housing provider..
13. Overnight Absences:
    a. Absences from the house without permission from staff is not allowed.
    b. Clients may obtain permission for overnight absences based on the individual program rules.
14. House Chores
    a. Each client must complete chores as described by the housing provider and must keep his/her personal areas clean and orderly. This includes, but is not limited to, the kitchen, bathroom and bedroom.
    b. Clients must periodically help with major chores, such as spring and fall cleanup, major house cleaning, painting, moving furniture, etc.

c. Room checks may be done at any time by staff.

15. Cars
    a. Any motor vehicle on the property must be registered and insured, and each program participant is limited to one motor vehicle.
    b. All drivers must have valid driver's licenses.
    c. Cars must be in working condition.
16. Departure and Discharge
    a. All clients will be discharged from SRH services after 60 days.
    b. Staff will help clients to secure more permanent housing based upon their recovery plan.
17. Personal belongings
    a. I agree to accept full responsibility for any personal property. I have been advised to not bring any item of sentimental or significant monetary value into the house because of risk of loss or theft.
    b. I agree to hold the program and staff harmless from any and all losses I may have, from theft or otherwise. I understand that my belongings are not insured unless I obtain my own insurance policy at my own cost.
    c. Upon leaving program for any reason whatsoever, I will immediately remove my personal belongings. All personal belongings will be donated after three (3) days, with no compensation.

I, _____, agree to follow all rules.

Client Signature _____ Date _____

Staff Signature _____ Date _____

VIOLATION OF ANY RULE MAY RESULT IN IMMEDIATE DISCHARGE FROM HOUSE.

GRIEVANCE PROCEDURE

CLIENT RIGHTS

All services at _____ (Program Name) are voluntary. Even after accepting services, clients have a right to terminate services at any time. Applicants for services will have equal access and can expect to be treated with respect regardless of their gender, race/color/national origin, age, sexual orientation, or physical/mental disability.

GRIEVANCE PROCEDURE

If you do not think you are being afforded your rights, or believe you have been treated unfairly, you should file a grievance with the program's designated staff member per the posted grievance policy. A grievance may be filed verbally or in writing and should contain at a minimum a full description of the event, the date it occurred, the persons involved, and a reasonable expected outcome. If you do not feel that your grievance is being handled appropriately, you may contact the program supervisor or program director. If you are not satisfied with the outcome of the grievance at the program, you may contact General Assistance Recovery Support Services (GA RSP) at (800) 658-4472 or Access to Recovery (ATR) II at (866) 580-3922. You are required to try to resolve your grievance at the program level before calling GA RSP or ATR II.

You may not be threatened, penalized or have your services negatively affected solely for filing a grievance.

Client Signature: _____ Date: _____

STATE OF CONNECTICUT
Department of Mental Health and Addiction Services
SUPPORTED RECOVERY HOUSING SERVICES

INTAKE SUMMARY

Demographics

Name: _____ Phone: ( ) _____- _____

Previous address: _____ City_____ Zip _____

Social Security #: _____-_____-_____ Date of birth: _____/_____/_____

Relationship Status Civil Union ☐ Divorced ☐ Domestic Partner ☐ Married ☐ Separated ☐ Significant Other ☐
Single ☐ Widowed ☐ Other (Please specify):

Race American Indian/ Alaska Native ☐ Asian ☐ Black/African American ☐ Multi-racial ☐ Native Hawaiian/Pacific Islander ☐
White ☐ Other (Please specify):

Ethnicity Hispanic – Cuban ☐ Hispanic – Mexican ☐ Hispanic – Puerto Rican ☐ Hispanic – Other ☐
Non-Hispanic ☐ Unspecified ☐

Primary Language: _____ Religious/Spiritual Practice: _____

Emergency contact: _____ Phone: ( ) _____ - _____ Relationship: _____

Emergency contact address: _____

Legal Information/History

Pending Case(s): Yes ☐ No ☐ Previous Involvement with the Criminal Justice System: Yes ☐ No ☐

Currently on probation? Yes ☐ No ☐ Parole? Yes ☐ No ☐ Conservator? Yes ☐ No ☐

Criminal Justice Contact: _____ Telephone: _____

Health Status

	Currently Experiences or Uses	History Of	In Treatment For	Not Applicable
Psychiatric conditions				
Addiction disorders				
Medical Conditions				
Trauma/ Abuse				
Prescribed Medications				

Current problems: _____

Allergic reactions (Include Medication): _____

Current provider agency: _____ Admission date: _____

Current Doctor/Clinician/Worker: _____ Phone #: ( ) _____ - _____

Medications prescribed during current treatment: _____

Do you attend AA/NA? _____ YES _____ NO When did you last use? _____

What is your longest period of sobriety or stability? _____

Entitlements and Benefits

SAGA Status: Active ☐ Not Active ☐ Pending ☐ Spend-down ☐ EMS #: _____

SAGA Type: SAGA Cash ☐ SAGA Medical ☐

Benefit: Title 19 ☐ Medicaid ☐ Social Security Disability (SSD) ☐ Supplemental Security Income (SSI) ☐ TANF ☐ Food Stamps ☐ Other (Specify) ☐ _____

Other State/Provider Agency Involvement

Have you ever been on active military duty? _____ Yes _____ No

Are you currently working with another agency/case manager? (e.g. DCF, GAICM)? _____ Yes _____ No

If yes, what is the name of your worker: _____ Phone Number: ( ) _____ - _____

Referral Source

Who referred you to this program? _____

Family and Supports

How would you describe your current relationship with your family members? _____

_____

Do any of your immediate family members have service needs? If yes, please explain. _____

_____

Do you currently have a sponsor? No ☐ Yes ☐ Not sure ☐

Employment Status

Employed FT ☐ Employed PT ☐ Unemployed (but looking for work) ☐ Not in the Labor Force ☐

Volunteer ☐ Other (Specify) ☐:

Housing Status

Where have you slept for the last 30 days? Check all that apply:

Non Housing (street, park, car)	☐	Emergency Shelter	☐	Transitional Housing	☐	Inpatient Facility	☐	Hospital	☐
Prison/Jail	☐	Family/Friends	☐	Rental Housing	☐	Owned housing	☐	Motel/Hotel	☐

Reason for leaving the last housing situation: _____

Within the last 4 years, approximately how much time have you lived in a shelter? _____

Is client at risk of homelessness? No ☐ Yes ☐ Not sure ☐

STATE OF CONNECTICUT
Department of Mental Health and Addiction Services
SUPPORTED RECOVERY HOUSING SERVICES

In the Client's Own Words

I need help with the following:

Housing		Medical Care		Education		Hygiene		Cleaning	
Paying Rent/Utilities		Shopping & Meal Preparations		Mental Health Services		Substance Abuse Services		Health and Wellness Services	
Securing Benefits		Money/Debt Management		Opening a Bank Account		Taking Medication		Legal Assistance	

What do you think is your biggest or most challenging issue? _____

_____

Are you interested in maintaining a sober lifestyle? No ☐ Yes ☐ Not sure ☐

What are the relapse triggers you can recognize? _____

_____

What are your strengths? _____

_____

What are your short-term goals? _____

_____

What are the barriers to your goals? _____

_____

What specific assistance or support would best help you to reach these goals? _____

_____

Is there anything else you can tell us about yourself that would assist us in helping you meet your goals? _____

_____

_____ _____

Program Staff Signature Date

_____ _____

Client Signature Date

STATE OF CONNECTICUT
Department of Mental Health and Addiction Services
SUPPORTED RECOVERY HOUSING SERVICES

RECOVERY PLAN

CLIENT NAME: _____ DATE: _____

Suggested Goals: Maintain recovery, Locate stable housing, Locate full-time employment, Apply for relevant benefits or entitlements, (Re)establish community network, Secure basic needs/transportation, Access treatment services.

GOAL					
STEPS CLIENT WILL TAKE TO REACH GOAL					
WHEN GOAL BE ACHIEVED (select one)	15 days	30 days	45 days	60 days	Ongoing
PROGRESS AT DISCHARGE (select one)	Met Goal	Partially Met Goal		Goal Revised	Goal Not Met

GOAL					
STEPS CLIENT WILL TAKE TO REACH GOAL					
WHEN GOAL BE ACHIEVED (select one)	15 days	30 days	45 days	60 days	Ongoing
PROGRESS AT DISCHARGE (select one)	Met Goal	Partially Met Goal		Goal Revised	Goal Not Met

Client Signature _____ Date _____

Program Staff Signature _____ Date _____

STATE OF CONNECTICUT
Department of Mental Health and Addiction Services
SUPPORTED RECOVERY HOUSING SERVICES

JOB READINESS INFORMATION

CLIENT NAME: _____ DATE: _____

Please include information explaining job readiness efforts. This may include job searches, vocational training, posting resumes online, treatment related employment groups, online education, etc.

_____

_____

_____

List all job search contacts:

	Date	Company & Position	Contact Person & Phone #	Type of Contact *i.e.: Sent resume or interviewed*
1				
2				
3				
4				
5				

List all vocational training contacts:

	Date	Type of Training	Contact Person & Phone #	Dates of Training
1				
2				
3				
4				
5				

PROGRESS NOTE

Client Name: _____

At a minimum, answer each of the following questions in each note: Is client maintaining recovery? Is client making progress towards goals? Has client expressed additional needs? How is the case manager helping client in these areas?

Direct ____ Indirect_____ Provided Referral _____	Service Date:
Note:	
Case Manager Signature:	Time (in minutes):

STATE OF CONNECTICUT
Department of Mental Health and Addiction Services
SUPPORTED RECOVERY HOUSING SERVICES

DISCHARGE SUMMARY

Client Name:	
Date of Admission:	Date of Discharge:

Discharge Reason(check all that apply):

___ Completed Program
___ Inpatient Treatment Needed
___ Against Staff/Program Advice
___ Moved out of area
___ Non-compliance with rules
___ Services continued elsewhere
___ AWOL
___ Arrested/ Violated
___ Medical Treatment Needed
___ Died

Employment Status (check one):

___ Unknown
___ Not in Labor Force
___ Employ. FT
___ Employ. PT (less than 35 hrs./ wk)
___ Unemployed, looking for work
___ Volunteer & Unemployed
___ Volunteer & Not in the Labor Force

Living Situation (check one) :

___ Unknown
___ Institution
___ Private Res. w support
___ Correctional Facility/Jail
___ Private Res. w/o support
___ Homeless/shelter
___ 24 hr. Res. Care
___ Other (Please specify)_____

Referrals Made (if any) and any additional comments:

_____

_____

_____

_____

_____ _____

Signature of Program Staff Date

STATE OF CONNECTICUT
Department of Mental Health and Addiction Services
SUPPORTED RECOVERY HOUSING SERVICES

SIGN IN/OUT SHEET

Provider		Date
Site Address		

CLIENT NAME (PRINT)	CLIENT SIGNATURE	DATE (mm/dd/yy)	TIME IN	TIME OUT
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				
14.				
15.				

Date Reviewed by Program Staff_____

Program Staff's Signature _____

STATE OF CONNECTICUT
Department of Mental Health and Addiction Services
SUPPORTED RECOVERY HOUSING SERVICES

Provider Verification Form

To expedite processing of this request, please complete this form and fax to:
General Assistance Recovery Supports Program (GA RSP) Fax #: 1-866-249-8766

_____ has indicated that he/she will be residing at:
(Name of program participant/client)

_____
(Program Name)

_____
(Address participant is/will be residing)

Admission Date: _____

Program Staff's Signature: _____ Date: _____

By signing this form, I understand that I am attesting to the truth of the information above, including compliance with local zoning regulations. I further understand that this information is subject to verification and audit, and that intentional misrepresentation may lead to criminal prosecution.